SAMPLE

Page _____ of _____ Month/Year _____

AFTER HOURS PHYSICIAN CONSULTATION LOG

Employee Name: _____ Bureau: _____ Office: _____ P/L: _____

Employee No.: _____ Payroll Title: _____ Work Phone No.: _____

Supervisor's Name: _____ Work Phone No.: _____

Date/ Time	Case/Client Name	Nature of Consultation	On-Duty Staff/Office With Whom Consulted	Ending Time	Results of Consultation

I certify that the information entered above is true and correct. I understand that falsification or misrepresentation on this form may result in disciplinary action including discharge.

_____ _____
Employee Signature Date

I have verified the information reported on this form. It is true and correct to the best of my knowledge and belief. In signing this form and the employee's timecard, I understand that I am authorizing payment of County funds in accordance with Departmental policy.

_____ _____
Supervisor's Signature Date

Complete in Duplicate

Retain original for 3 years in office payroll files

Copy for employee